

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02039

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Queen AnneCity or town Rural Centerville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Rural Cardora
(If outside city or town limits, write RURAL and give nearest town)

Street No.

2. (a) If veteran, name was Served ten years in Army between 1910 and 1920
(If rural, give LOCATION)

3. (a) FULL NAME

Thomas Manship Breeding

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed or divorced

Married

6. (b) Name of husband or wife

Marquise Ellis

7. Birth date of

deceased (mo., day, yr.)

Oct 13 - 19026. (c) If alive, give age 30 years

8. AGE:

Years

Months

Days

If less than one day

42328

hrs.

min.

9. Birthplace

Goldensboro, Calverton Co., Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

18. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. 2-14-

19. 45

Elicie Ametroug

Registral

Date rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 10th 1945 at 7:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... on 19...

Immediate cause of death Compound fracture of skull fracture base of skull

DURATION

Due to

Due to

Other conditions

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-10-45Where did injury occur? Rural, Calverton Co., Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) public placeMeans of injury Struck by auto Injured at work? no23. SIGNATURE Samuel J. Price M.D.Address Centerville, Md.Date signed 2-10-45

RECORDED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 253

1. PLACE OF DEATH:

County QUEEN ANNE
 City or town STEVENSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County QUEEN ANNE
 City or town STEVENSVILLE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, same war _____

3. (a) FULL NAME

Daniel Hopkins

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6. (b) Name of husband or wife ELVA ADELE7. Birth date of deceased (mo., day, yr.) Sept. 3, 1869 6. (c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
75 5 7 _____ hrs. _____ min.9. Birthplace STEVENSVILLE, QUEEN ANNE Co. Md.
 (Town, county, and state)10. Usual occupation FARMER

11. Industry or business

12. Name JAMES BATEMAN Hopkins13. Birthplace KENT ISLAND, Md.14. Maiden name MARY ELIZ Anderson15. Birthplace CHESTER TOWN, Md.16. Informant EDWARD DANIEL HopkinsAddress 1018 Roland Hts. Ave BALTO, Md.17. BURIAL Date thereof Feb. 13, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory STEVENSVILLELocation KENT ISLAND, MARYLAND19. Funeral director FRANK THOMASAddress STEVENSVILLE, MARYLAND19. 2/10 19 45 F. C. Thomas
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Febr. 10 19 45 at 1:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febr. 10 19 45 to Febr. 10 19 45and that I last saw him alive on Febr. 10 19 45

Immediate cause of death _____ DURATION

coronary thrombosis Febr. 10
 Due to with occlusion 1945

coronary sclerosis about
 Due to angina pectoris one year

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Theodor Sattelmaier M.D.Address Stevensville M. D. or other _____Date signed 2/10/45

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BURIAL

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

17. SIGNATURE OF DECEASED

18. SIGNATURE OF DECEASED

19. SIGNATURE OF DECEASED

20. SIGNATURE OF DECEASED

21. SIGNATURE OF DECEASED

22. SIGNATURE OF DECEASED

23. SIGNATURE OF DECEASED

24. SIGNATURE OF DECEASED

25. SIGNATURE OF DECEASED

26. SIGNATURE OF DECEASED

27. SIGNATURE OF DECEASED

28. SIGNATURE OF DECEASED

29. SIGNATURE OF DECEASED

30. SIGNATURE OF DECEASED

31. SIGNATURE OF DECEASED

32. SIGNATURE OF DECEASED

33. SIGNATURE OF DECEASED

34. SIGNATURE OF DECEASED

35. SIGNATURE OF DECEASED

36. SIGNATURE OF DECEASED

37. SIGNATURE OF DECEASED

38. SIGNATURE OF DECEASED

39. SIGNATURE OF DECEASED

40. SIGNATURE OF DECEASED

41. SIGNATURE OF DECEASED

42. SIGNATURE OF DECEASED

43. SIGNATURE OF DECEASED

44. SIGNATURE OF DECEASED

45. SIGNATURE OF DECEASED

46. SIGNATURE OF DECEASED

47. SIGNATURE OF DECEASED

48. SIGNATURE OF DECEASED

49. SIGNATURE OF DECEASED

50. SIGNATURE OF DECEASED

51. SIGNATURE OF DECEASED

52. SIGNATURE OF DECEASED

53. SIGNATURE OF DECEASED

54. SIGNATURE OF DECEASED

55. SIGNATURE OF DECEASED

56. SIGNATURE OF DECEASED

57. SIGNATURE OF DECEASED

58. SIGNATURE OF DECEASED

59. SIGNATURE OF DECEASED

60. SIGNATURE OF DECEASED

RECEIVED
MAR 3 1945
BUREAU T.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02041

Reg. Dist. No. 254

1. PLACE OF DEATH:

County Queen Anne
 City or town Queenstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all of life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Queen Anne
 City or town Queenstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Fanny Hatchkins

3. (b) Social Security Number

none

4. Sex

Female Colored. Single

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec 12-1894

8. AGE:

50

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Queenstown Rural
(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

FATHER

12. Name

Fanny Hatchkins

13. Birthplace

Queenstown Md

MOTHER

14. Maiden name

Susan Little

15. Birthplace

Queenstown Md

16. Informant

Address

Wladford Hatchkins
Queenstown Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar 1st 45
(month) (day) (year)

Cemetery or crematory

Home, near John Thelley Church

Location

Queenstown Rural Md.

18. Funeral director

Address

John D. Williams
Exton Md.

19.

(Date rec'd by registrar)

19.

45 J. M. Reddick
Ex. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 26 1945 at 3 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 26 1945 to Feb 26- 1945
and that I last saw or alive on Feb 26- 1945

Immediate cause of death

DURATION

Cerebral Hemorrhage 3 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Data of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Henry Fisher

M. D. or other

Address

Centreville MdDate signed 2/27/45

RECEIVED

MAR 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Green AnneCity or town Church Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Green AnneCity or town Church Hill
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Emma Rochester Meredith

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife James B. Meredith

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 30 - 18638. AGE: Years 81 Months 8 Days 10 If less than one day _____ hrs. _____ min.9. Birthplace Green Anne Co. Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John Woodale
13. Birthplace Green Anne Co. Md.14. Maiden name Mrs. Elin Elliott
15. Birthplace Green Anne Co. Md.16. Informant Mrs. Edith Miller
Address Church Hill Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 11 - 1945
(month) (day) (year)Cemetery or crematory Church Hill Cem.Location Church Hill Md.18. Funeral director Edgar S. LaneAddress Church Hill Md.19. Feb. 11 19 45 Edgar S. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 9 19 45 at 2 1/2 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 19 44 to Feb 9 19 45
and that I last saw him alive on Feb 9 19 45Immediate cause of death Heart from Dissection
Due to Coronary Artery DiseaseDue to Myocardial InfarctionOther conditions None
(Include pregnancy within 3 months of death)Major findings of operations Block from Dissection
Date of operation Feb 9 1945Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. ✓ Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury None Injured at work? None23. SIGNATURE Edgar S. Lane M. D. or otherAddress Church Hill Date signed Feb 10

RECEIVED

MAR 7 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

12043

Evidence for change of

age is shown on
FILM No. G 94 MAY 11 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH

County Queen Anne's
City or town Near Millington
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution Palmaroy Nursing Home
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) 1 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Kent
City or town Lahara Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. _____
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Annie Moore

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Sept 2 1850

8. AGE:

89

80

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

James Ellis

13. Birthplace

Maryland

MOTHER

14. Maiden name

Susan Bramble

15. Birthplace

Delaware

16. Informant

Mr. Edgar Hadley

Address

Lahara Md

17.

(Burial, cremation, or removal. Which?)

Date thereof March 1, 45
(month) (day) (year)

Cemetery or crematory

Lahara

Location

Lahara Md

18. Funeral director

Edward T. Elbow

Address

Millington Md

19.

Feb. 28

19

45 E. L. Lane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 26

1945, at _____ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb. 18 1945, to Feb 26 1945

and that I last saw her alive on _____ 1945

Immediate cause of death

Hemiplegia hemiplegia

DURATION

1 mo

Due to

Anterior Infarct anterior infarct stroke

Due to

Fracture of Hip fracture of hip

Accidental fall Accidental fall

Other conditions Paralytic stroke

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident

Date of February 18, 1945

Where did injury occur? Millington

(City or town)

(County)

Maryland
(State)

Injured at home, farm, industry, public place (where?) Nursing Home

Means of injury _____

Injured at work? _____

23. SIGNATURE

Muriel Brice

M. D. or other

Address _____

Millington Md

Date signed 2/25/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5-1
5-3
5-5
5-7
5-9
5-11
5-13
5-15
5-17
5-19
5-21
5-23
5-25
5-27
5-29
5-31

RECEIVED
MAR 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92nd)

CERTIFICATE OF DEATH

Reg. Dist. No.

02044

254

1. PLACE OF DEATH:

County Queen AnneCity or town Brownsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Brownsville
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

James Alfred Pierson

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary Stafford

7. Birth date of

deceased (mo., day, yr.)

August 25- 1849

B. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9562

hrs.

min.

9. Birthplace

Baltimore Maryland
(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

FATHER

12. Name

Do not know

13. Birthplace

" " "

MOTHER

14. Maiden name

Do not know

15. Birthplace

" " "

16. Informant

Address

Alfred Norman Pierson
Brownsville Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 2- 1945
(month) (day) (year)

Cemetery or crematory

Centerville

Location

Centerville Maryland

18. Funeral director

Address

Barton Bros
Centerville, Maryland

19. Mar. 2-

19 45H. M. Aldridge

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 27 19 45 at 730 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 19 44 to Feb 27 19 45
and that I last saw him alive on Feb 27 19 45

Immediate cause of death

Mitral Stenosis

DURATION

6 mos

Due to

Due to

Other conditions

Arteriosclerosis

(include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Chas E Taylor

M. D. or other

Address

Stevensville Md

Date signed

2/28/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAR 6 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Augustus Reading

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

8. (b) Name of husband or wife

Augustus Reading

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

75

hrs.

min.

9. Birthplace

Kent Co. Md.
(Town, county, and state)

10. Usual occupation

H. W.

11. Industry or business

John Reading

12. Name

13. Birthplace

Md.

14. Maiden name

Don't know

15. Birthplace

Annapolis, Md.

16. Informant

Augustus Reading

Address

Annapolis, Md.17. Buried

(Buried, cremation, or removal. Which?)

Date thereof

2/15/45

(month) (day) (year)

Cemetery or crematory

Centerville

Location

Centerville, Md.

19. Funeral director

Edgar Lane

Address

Church Hill

19. Feb. 14 - 19 45

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Anne Arundel

City or town

Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/12

19

45

at

3

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-10

18

44

to

2-12

19

45

and that I last saw him

2-10

alive on

2-10

18

45

Immediate cause of death

Paralysis

Due to

Hypertension

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. S. Matthews

M. D. or other

Address

Annapolis, Md.

Date signed

2/13/45

CERTIFICATE OF DEATH

RECEIVED

MAR 6 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen Anne

City or town Sudlersville
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) as before

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Queen Anne

City or town Rural Sudlersville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Patricia Ann Solloway

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

May 15, 1944

8. AGE:

Years

Months

Days

If less than one day

9

6

hrs.

min.

9. Birthplace Queen Anne
(Town, county, and state)

10. Usual occupation

NONE

11. Industry or business

FATHER

12. Name Clarence A Solloway

13. Birthplace Queen Anne County

14. Maiden name Helena Marie Hurd

15. Birthplace Massey Md.

16. Informant

Clarence Solloway

Address

Rural Sudlersville Md.

17. Burial
(Burial, cremation, or removal, which?)

Date thereof Feb. 22 1945
(month) (day) (year)

Cemetery or crematory

Haldens

Location

near Millington Md

18. Funeral director

Edward Solloway

Address

Millington Md.

19. Feb. 22 19 45
(Date rec'd by registrar)

Edgar L. Lane
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 21 19 45, at 7:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 15 19 44, to Feb. 21 19 45

and that I last saw her alive on Feb. 21 19 45

Immediate cause of death Bronche Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. B. Copeland

M. D. or other

Address

Millington

Date signed Feb. 22

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 12047 251

1. PLACE OF DEATH:

County Queen AnneCity or town Kingston
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Queen AnneCity or town Kingston near Chestertown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

William B. Stafford3. (b) Social Security Number
none4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Mary Frances Stafford

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 18598. AGE: Years 86 Months I Days 14 if less than one day
..... hrs. min.9. Birthplace Queen Anne Co. Maryland
(Town, county, and state)10. Usual occupation Mail Messenger11. Industry or business Chestertown, Postoffice12. Name Theodore Stafford13. Birthplace Maryland14. Maiden name Eliza Faulkner15. Birthplace Maryland16. Informant Kennard StaffordAddress Seaford Delaware17. Burial Date thereof Mar. 2, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chesterfield CemLocation Centreville, Maryland18. Funeral director J. Willis WellsAddress Chestertown, Md.19. Feb. 27 19 45 C. D. Lane
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-26 19 45 at 8 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-18- 19 45 to 2-26 19 45and that I last saw him alive on 2-26 19 45Immediate cause of death heart failure DURATIONDue to Lobar Pneumonia

Due to

Other conditions Age

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Bohland M. D. or otherAddress Chester Town Ind Date signed 2-27-45

RECEIVED
MAR 7 1945
BUREAU U.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

02048

1. PLACE OF DEATH

County Queen Anne
Village or City QueenstownRegistration Dist. No. 254

No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred. 50 yrs. mos. ds.

How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Lavinia Simmons(a) Residence: No. Queenstown

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

widowed5e. If married, widowed, or divorced
HUSBAND of
(or) WIFE ofdeceased

6. DATE OF BIRTH (month, day, and year)

July 21-1853

7. AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.9174

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Housewife9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.own home10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)Penn. Loc. Haven
Pennsylvania

FATHER

13. NAME

George Bailey14. BIRTHPLACE (city or town)
(State or country)Pennsylvania

MOTHER

15. MAIDEN NAME

Elizabeth Bailey16. BIRTHPLACE (city or town)
(State or country)Pennsylvania17. INFORMANT
(Address)Mrs. Hattie Post
Queenstown - Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Stevensville, Md. Date Feb. 27, 1945

19. UNDERTAKER

(Address) Frank E. Thomas
Stevensville, Md.

20. FILED

Feb. 27, 1945 H.M. Aldridge

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Feb. 25, 1945
(Month) (Day) (Year)

22.

I HEREBY CERTIFY That I attended deceased from

Jan 1, 1944, to Feb 25, 1945I last saw her alive on Feb. 24, 1945, death is saidto have occurred on the date stated above, at 6 a m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Date of onset

Cerebral embolism2/23

Other Contributory Causes of importance

Arteriosclerosis18 yrs.

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

Raymond M. Myers M. D.

(Address)

Queenstown

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02049 255

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Sarah Catherine Wilcox
 4. Sex.....
 5. Color or race.....
 6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.
 9. Birthplace.....
 (Town, county, and state)
 10. Usual occupation.....
 11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial, cremation, or removal? Which?..... Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. (Date rec'd by registrar).....

Registrar.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him..... alive on.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

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Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... M. D. or other

Address..... Date signed.....

RECEIVED - DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED
MAR 7 1945
BUREAU V.S.